

Utilization of Palliative Care: Providers Still Hinder Access

Provision of compassionate, quality care for individuals with chronic illness is a challenge to today's health care system.¹ There is considerable evidence that patient suffering is not adequately addressed during treatment and that patient preferences are neglected at the end of life. The Jefferson Palliative Care Service investigated end-of-life care for hospitalized patients with lung cancer and found barriers to palliative care access typical of those reported elsewhere in the US.²

Confusion about the difference between palliative care and hospice is at the heart of the matter. These care delivery options are often misconstrued as synonyms for care in the final days of life. While both aim to prevent and treat suffering, provide clear communication about treatment options, and align patient wishes with health care decisions, access to care is different.³

Palliative care is considered an ongoing component of disease-modifying treatment intended to alleviate symptoms and manage pain at any stage of disease; hospice is holistic end-of-life care for individuals no longer receiving aggressive treatment and who are expected to die within 6 months. Palliative care can be provided by a hospital-based specialty team in more than 80% of US hospitals. Hospice care is usually provided by home-based health care providers, although inpatient hospice units are available in some acute care hospitals and skilled nursing facilities. Both palliative care and hospice rely on interdisciplinary collaboration among doctors, nurses, chaplains, social workers, physical and occupational therapists, and volunteers.

From the scientific side of the matter, findings from randomized controlled trials demonstrate that palliative care promotes pain and symptom relief, improves patient/family satisfaction with care, facilitates earlier transitions to hospice, lowers health care costs without affecting mortality and lengthens survival.⁴⁻⁷ Despite the emerging evidence, health care providers typically wait to suggest palliative care when medical treatments are exhausted or death appears imminent.⁸ Exploring the reasons for underutilization of palliative care uncovers further barriers.

Health care providers are often unsure when patients with advanced illness are ready for palliative care or hospice and are reluctant to initiate end-of-life conversations.⁸ Both doctors and nurses acknowledge lack of training in end-of-life communication and when to suggest a transition to palliative care. Patients and their families share cultural attitudes about death and the role of health care which further hampers this communication.

Persons with advanced lung cancer can potentially benefit from palliative care involvement soon after diagnosis and during treatment due to their high symptom burden.⁶ During its first 3 years in operation, the Jefferson Palliative Care Service noticed that lung cancer topped its list of diagnoses referred for consultation and that referrals usually came when patients were close to death. The service was most often consulted to discuss end-of-life care options, but less frequently for pain and symptom management or emotional support. A median of 6 hospital days elapsed before a

palliative care referral was made. Compared to usual care patients, the palliative care patients had a longer length of stay, higher mortality and greater percentage of hospice enrollment. These referral patterns reflect a delay in referral until late in the disease trajectory and underutilization of the service to address symptoms and psychosocial concerns. Palliative care professionals were consulted for only 8% of all hospital admissions among this patient population.

The National Quality Forum has identified palliative care as a priority for action to improve care of individuals with chronic illness.¹ At Jefferson, the analysis of referral patterns for lung cancer was an impetus to employ strategies to overcome provider barriers and promote palliative care referrals earlier in the course of the disease. A planned initiative will include provider education on specific referral triggers for palliative care, such as repeated or lengthy hospitalization, decline in cognitive or functional status, unacceptable pain, symptoms or emotional distress. Outcomes will be assessed by analyzing changes in provider referral patterns such as frequency and reasons for referral, observation of timing of referrals within the hospital stay and the disease course, and type of post-hospital care. Improving our nation's health care will involve concerted education, communication and institutional commitment to patient access to compassionate, quality palliative care during all phases of chronic illness. ■

Barbara Reville, MS, APRN-BC, ACHPN

*Assistant Director, Palliative Care Service
Jefferson Palliative Care Center*

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